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ABSTRACT

This consumer education document is intended to provide a complete description of Medicare's Prospective Payment System (PPS) for hospitals from the consumer's point of view and to provide basic information on how consumers can protect their rights to appropriate hospital care under Medicare. The first section describes the PPS and also explains how the Federal Government knows what a hospital stay is worth. The second section explains how the PPS may affect hospital care, answering questions regarding whether PPS applies to doctors' fees, whether PPS changes the care from physicians, how PPS affects hospital costs and Medicare benefits, and whether Medicare covers prepaid health plans. The third section addresses how patients can protect their right to the kind of care they need and the insurance coverage they deserve. It explains where patients can get help if they feel they have been treated unfairly, the responsibilities of a PRO (Peer Review Organization), what can be done when patients are told that Medicare will not cover their stay, what patients can do to avoid being discharged too early, what can be done if a PRO's decision is not in the patient's favor, and the type of PRO reviews that can be conducted after the patient is discharged. The next section gives examples of beneficiary discharge appeal rights. The document concludes with the name, address, and phone number of the PRO in each state and a patient checklist regarding the rights of hospital patients under Medicare. (CML)

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MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

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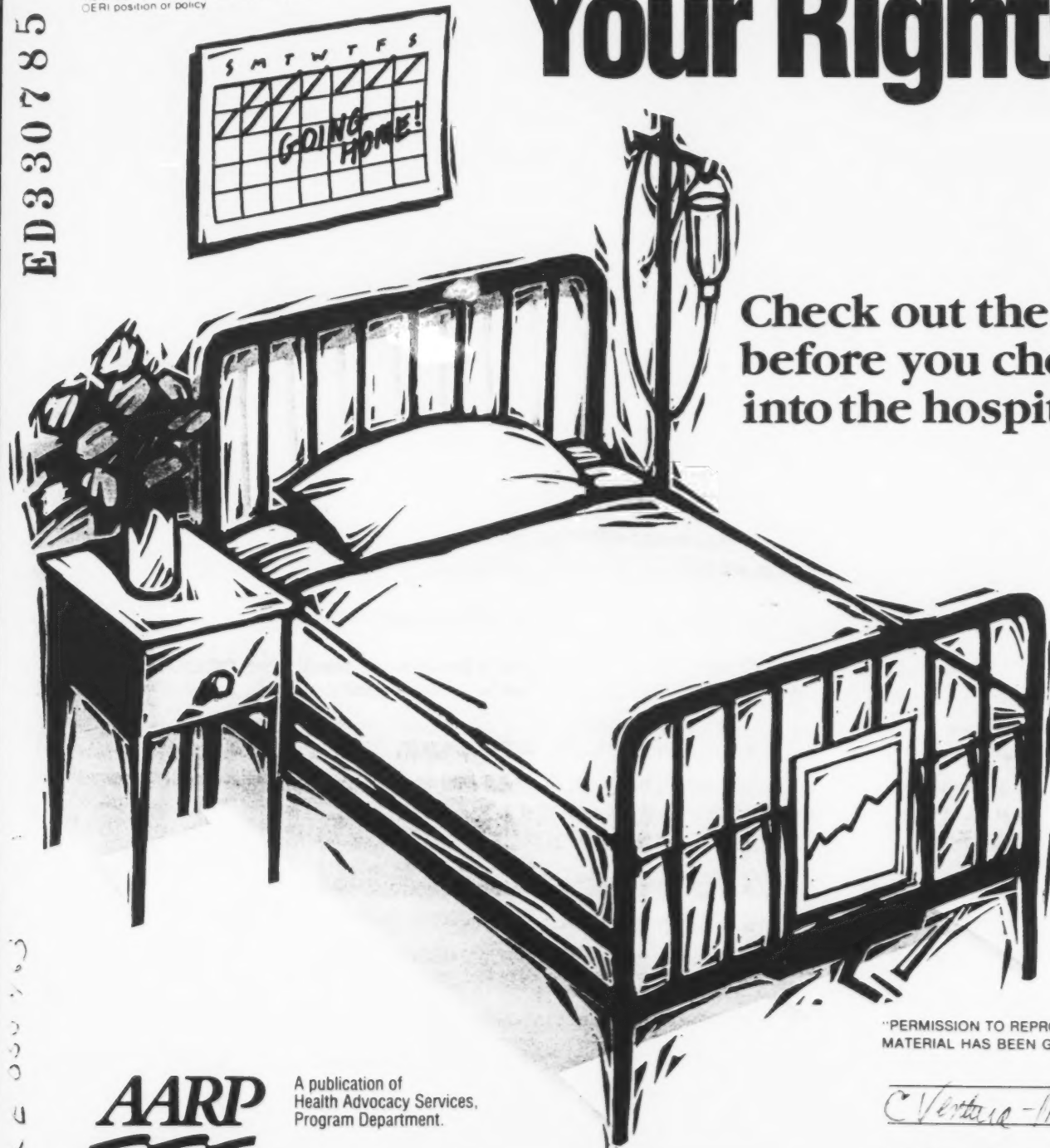
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Knowing Your Rights

Check out the facts
before you check
into the hospital.



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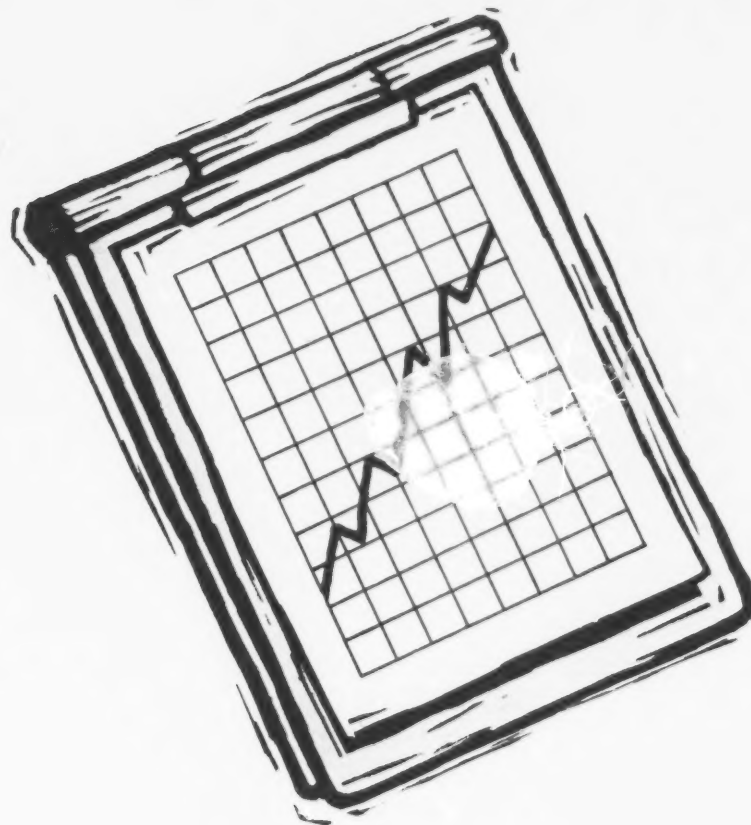
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cost
Keep
the care***

AARP's Health Care Campaign is designed to help reduce the sky-rocketing health care costs that are weakening our economy. The campaign includes political and consumer action, and health promotion activities. To learn how you can help, write: Health Care Campaign, AARP, 1909 K Street, N.W., Washington, DC 20049.

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There Is a Revolution Going On in America's Health Care System!

In 1983, Congress dramatically changed the way Medicare pays hospitals for treating Medicare patients. Called the *Prospective Payment System* (PPS), the new reimbursement method embodied the most far-reaching change in the Medicare program since it began in 1965.

The Prospective Payment System—involving set payments for each episode of hospitalization—was developed as a response to rapidly escalating hospital costs threatening the financial stability of the Medicare program. Hospitals have had a marked and rapid response to the incentives of the new system. During the first year of PPS (1984), the length of stay for Medicare beneficiaries fell by 9 percent. Medicare admissions fell by 4 percent, the first decline recorded by Medicare. Hospitals reduced expenses by laying off staff, eliminating beds, and negotiating lower prices with suppliers. Use of expensive inpatient services, such as intensive and cardiac care units, was curbed.

The American Association of Retired Persons (AARP) supports responsible efforts to reduce costs, so long as they do not infringe on patients' rights to receive quality hospital care. AARP, in fact, has an ongoing Health Care Campaign whose theme is "Cut the Cost and Keep the Care."

Changes in the Medicare reimbursement system require sustained vigilance to prevent any reduction in Medicare patients' accessibility to needed quality care.

Inflation in health care costs, shifting provider arrangements, new reimbursement mechanisms, the pace of technological breakthroughs, AIDS, the nursing shortage, and the federal budget deficit have created additional, enormous stresses on the health care delivery system, including the Medicare program. Thus, it is increasingly apparent that beneficiaries must be knowledgeable about their rights under Medicare, and informed about how to enforce them should that be necessary. An informed health care consumer is a key participant in controlling costs and in maintaining high standards of quality in health care. That's why the Association has written this booklet.

Specifically, this booklet provides a complete description of Medicare's *Prospective Payment System* for hospitals from the consumer's point of view. It answers many questions about PPS and provides basic information about how to protect your rights to appropriate hospital care under Medicare.

As we grow older the likelihood of hospitalization increases. It is up to us to prepare ourselves with the facts needed to make wise decisions about a future hospital stay.

A handwritten signature in cursive script that reads "Horace B. Deets".

Horace B. Deets
Executive Director
American Association of Retired Persons

What Is the Prospective Payment System?

The Prospective Payment System (PPS) is the system used by the government to pay hospitals for the care provided to Medicare patients. Begun on October 1, 1983, PPS was phased in to cover most hospitals in the United States during a four-year period.*

Before PPS, the federal government paid hospitals for the specific costs of caring for Medicare patients. Under the former payment system, hospitals were paid the cost of each procedure and test performed, and for each additional day a Medicare patient stayed in the hospital. Hospitals had strong financial incentives to keep patients longer and provide more care.

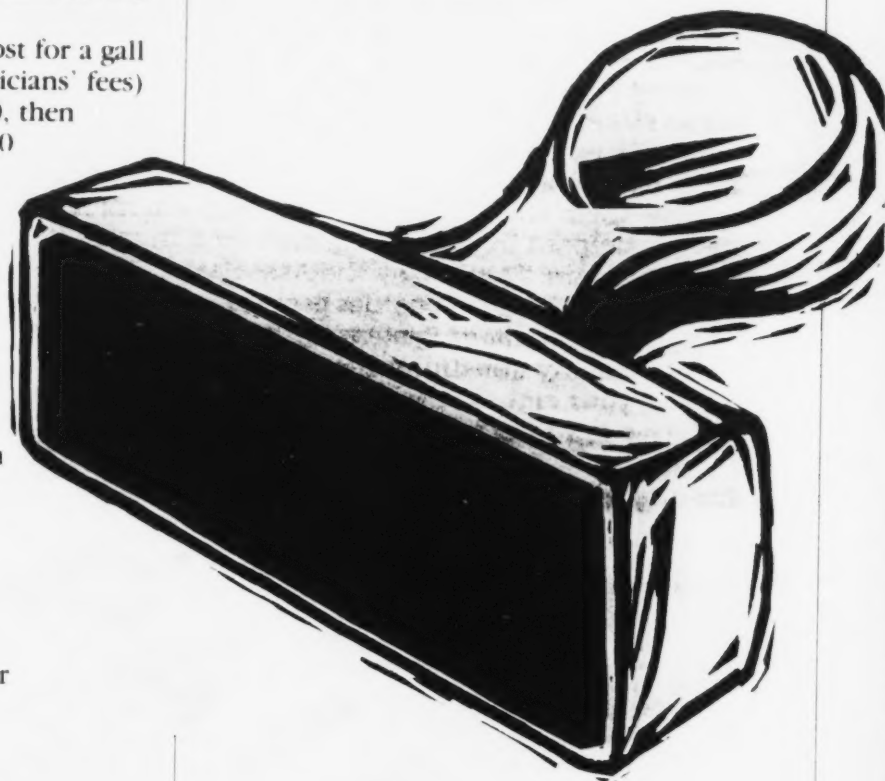
The Prospective Payment System reversed the incentives. Under PPS, Medicare generally pays a fixed amount to hospitals based on the average costs for similar cases.

For example, if the average cost for a gall bladder operation (excluding physicians' fees) has been determined to be \$3,000, then Medicare will pay hospitals \$3,000 for every Medicare patient that has gall bladder surgery in that

area. If the hospital spends more than that amount to care for a particular patient, it will still receive only \$3,000. Medicare patients are not responsible for the additional cost. If the hospital spends less than \$3,000 for a particular gall bladder surgical case, then it gets to keep the difference.

Overall, costs to hospitals for "severe" cases requiring longer than average hospital stays are expected to be offset by "mild" cases requiring shorter stays. However, when a stay is exceptionally long or costly—so-called "outlier" stays—Medicare will recognize this and make additional payments to the hospital. Despite these changes in how Medicare pays hospitals, Medicare patients remain entitled to all the hospital care necessary for the treatment of illness or injury.

Hospitals in Maryland, New Jersey, Guam, the American Territories, and the Virgin Islands are paid according to a different system from the one described in this section of the booklet. If you live in one of these areas, turn to page 8. There you will find material fully applicable to you concerning your rights to medically necessary care, appeals of decisions on hospital admissions and discharges, and the role of Peer Review Organizations.



How Does the Government Know What My Hospital Stay Is Worth?

Based on hospital costs in your area, the government sets a standard rate—or average

cost—for each category of treatment. These categories are called “Diagnosis Related Groups” or DRGs. There are currently 475 DRGs, such as for gall bladder removal or for coronary bypass surgery.

After patient discharge the hospital submits information about the patient and the reasons for hospitalization to insurance companies (known as fiscal intermediaries). The companies, which administer hospital claims under contracts from Medicare, then use that information to assign the appropriate DRG. The information includes:

The diagnosis that was determined to be the principal reason for hospital admission;

The surgical procedures performed in the hospital;

Any secondary diagnoses or complications that arise;

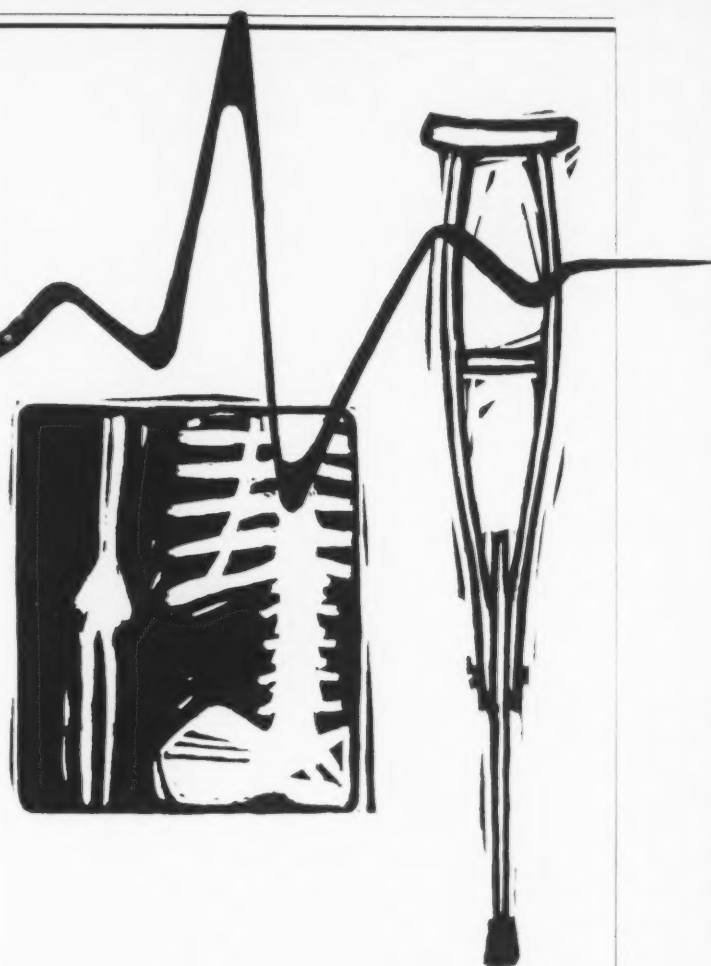
The patient’s age and sex; and

How the patient’s hospital stay ended—e.g., discharge to home, discharge to a skilled nursing facility, transfer to another hospital, etc.

Each Medicare patient’s hospital stay is assigned only one DRG, regardless of the number of services provided or the total number of days the patient spends in the hospital. In certain cases as noted above, however, PPS does make provisions for unusual medical circumstances or complications.

You may stay in the hospital at no additional charge (other than for applicable deductible and coinsurance amounts) for as long as your care is judged to be medically necessary and delivered in the most appropriate setting.

All hospitals are required to have a process called “discharge planning” to identify patients who will need post-hospital care and develop a plan for obtaining the care. As soon as you are admitted to the hospital, you, your family

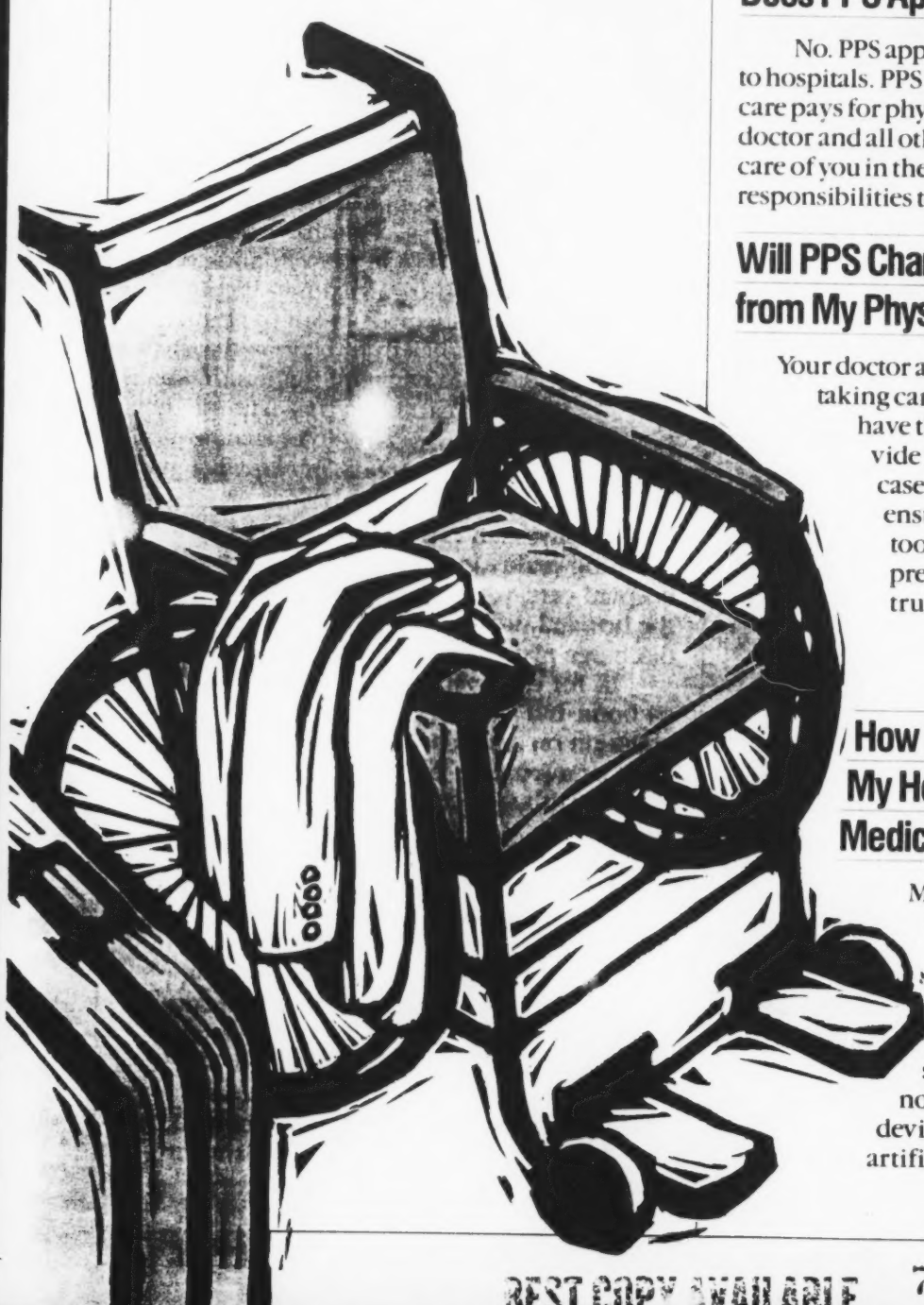


or your physician can request a discharge planning evaluation. If you will need post-hospital care, your physician can request that the hospital prepare and begin to implement a discharge plan.

If, for example, you are well enough to go home but still require some sort of medical attention on a regular basis—special medications or injections, perhaps—you may need home health services or homemaker services during your recuperation. Sometimes patients are discharged to a nursing home or other facility if medically necessary.

You should work with your physician, hospital staff, and family members in making these preparations. Both Medicare and supplemental insurance policies have limited coverage for nursing home and home health care. Therefore, you should find out which services will or will not be covered by Medicare and/or your supplementary insurance policy (if you have one) when you make plans for post-hospital care.

How the Prospective Payment System May Affect Your Care



Does PPS Apply to My Doctor's Fees?

No. PPS applies only to Medicare payments to hospitals. PPS does not affect the way Medicare pays for physician services. Moreover, your doctor and all other medical personnel taking care of you in the hospital still have the same responsibilities to provide for your care.

Will PPS Change the Care from My Physician?

Your doctor and all other medical personnel taking care of you in the hospital still have the same responsibilities to provide for your care. Under PPS, your case will be examined closely to ensure that hospital stays are not too long or too short and that prescribed medical procedures truly are needed.

How Does PPS Affect My Hospital Costs and Medicare Benefits?

Medicare's Prospective Payment System does affect your out-of-pocket costs. Before PPS began, Medicare hospital inpatients could have been billed separately for services such as laboratory and diagnostic tests or prosthetic devices, including cataract lenses, artificial limbs, and pacemakers.

These services now must be paid by the hospital. However, as in the past:

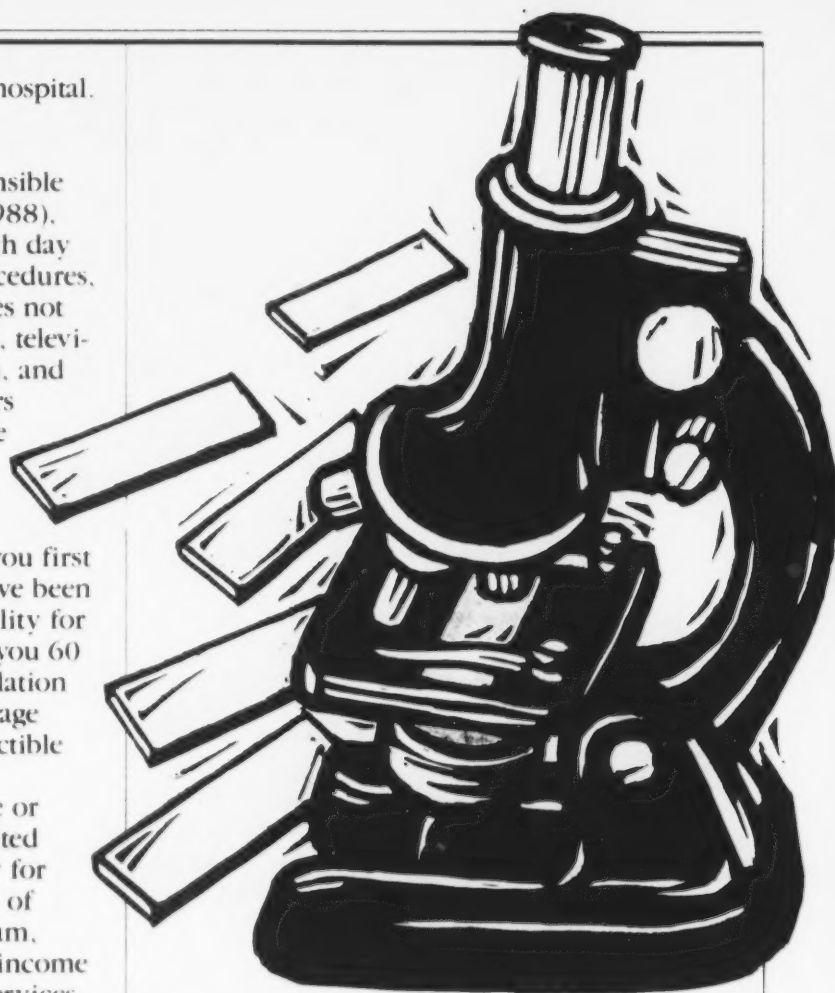
You, the Medicare patient, are responsible for the first day deductible (\$540 in 1988), co-insurance payments beyond the 60th day of hospitalization, and the costs of procedures, items and services which Medicare does not cover. These include telephone charges, television rentals, charges for a private room, and charges for care that Medicare considers experimental, excluded (not a Medicare benefit), or not medically necessary.

Medicare provides you with 90 days of inpatient hospital care per benefit period. (A benefit period starts when you first enter a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row.) Medicare also gives you 60 non-reusable reserve days. (Note: Legislation pending on catastrophic medical coverage could change Medicare's hospital deductible and coinsurance requirements.)

Medicare pays for nursing home care or home health care only under very limited conditions. Thus, you may have to pay for nursing home or home health care out of your own pocket. The Medicaid program, which helps pay medical bills for low-income people of all ages, may pay for these services, if you qualify.

Does Medicare Cover Prepaid Health Plans?

Some health maintenance organizations (HMOs) contract with the Medicare program to provide care for beneficiaries on a prepaid basis. For those beneficiaries who choose to enroll in such plans, the Medicare program pays the HMO a set amount each month for every beneficiary who joins. This amount is paid whether the beneficiary is healthy or sick. Unlike DRGs that pertain to specific diagnoses and procedures, HMOs that receive these payments from Medicare are agreeing to provide all Medicare-covered services. Members of HMOs may also be charged a monthly premium for benefits above and beyond those covered by Medicare.



Medicare HMO members can seek review of HMO noncoverage decisions and refusals to pay bills for services received outside the organization; members can also seek review of a complaint about the quality of care received. Information about such reviews can be obtained from a member's HMO, local Social Security Office, or the state Peer Review Organization (PRO). For a fuller explanation of the PRO role, see page 8.

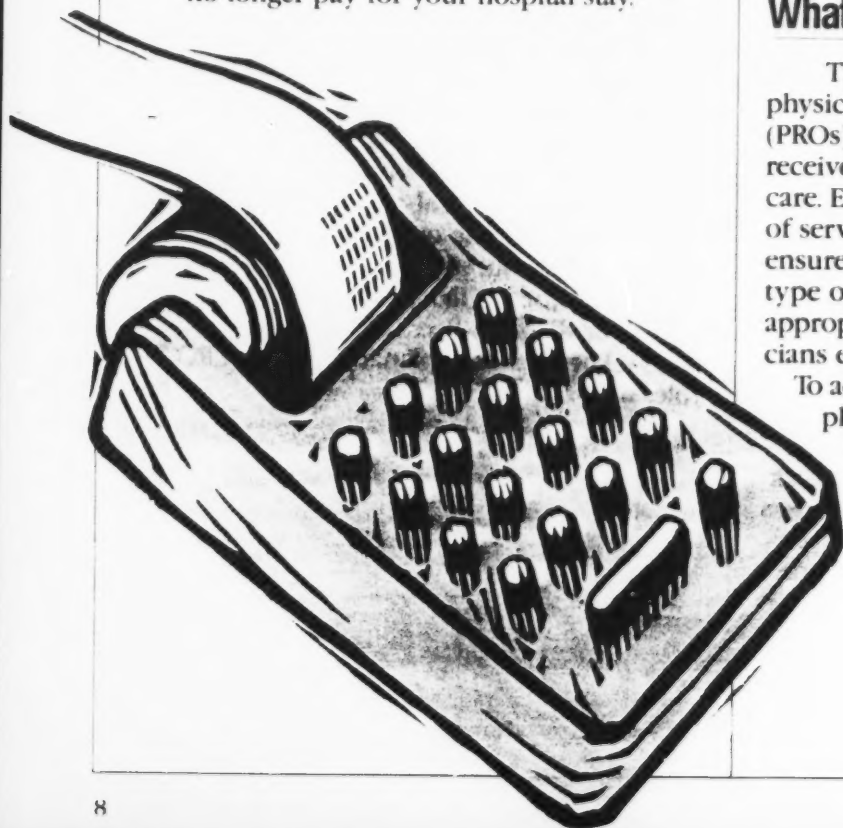
How to Protect Your Right to the Care You Need . . . and the Coverage You Deserve

You, the Medicare patient, have important, federally mandated rights to assert in the face of financial incentives that may adversely affect hospital care.

You have the right to receive all of the hospital care that is necessary and appropriate for the proper diagnosis and treatment of your illness or injury. Your discharge date should be determined solely by your medical needs, not by DRGs or by Medicare payments.

You have the right to be fully informed about decisions affecting your Medicare coverage or payment for your hospital stay.

You have the right to request a review, a reconsideration, and ultimately, an appeal of any written notices stating that Medicare will no longer pay for your hospital stay.



Who Can Help If I Feel I Have Been Treated Unfairly?

If you believe you have been refused admission to a hospital improperly, or you are being forced to leave a hospital too soon, or the quality of hospital care you received was inadequate, you (or a family member or friend) should discuss such concerns with your doctor and/or the hospital's patient representative or discharge planner. If you remain dissatisfied, however, you or your representative should contact the PRO for your area. (See the back of this booklet for a list.)

What Is a PRO?

The federal government contracts with physician-directed Peer Review Organizations (PROs) to ensure that Medicare patients receive necessary and good quality medical care. Each state has a PRO to monitor the quality of services provided to Medicare patients and ensure that the program pays only for the type of care which is medically necessary and appropriate. Peer review is conducted by physicians engaged in active practice in the state.

To accomplish the monitoring task, PROs use physicians and nurses to review a percentage of Medicare patients' medical records before and after hospitalization to make sure that the treatment provided:

Is medically necessary (on an in-patient or outpatient basis);

Meets the standards of quality established by the medical profession; and

Is provided in the most appropriate type of facility.

PROs also seek to ensure that adequate discharge planning is being performed.

The authority of PROs to oversee patient care (and associated costs) is not limited to individual patient cases. They also look at the broader picture—numbers of admissions, transfers and readmissions of hospital patients—to determine whether there are inappropriate patterns. They look at hospital bills to see that they accurately reflect patient diagnoses and treatments, and they examine unusual cases to assure that extra Medicare payments are being issued only when medically justified.

In cases where PROs find inappropriate or poor quality care, they have the authority to deny payment and to impose corrective actions or penalties against hospitals, physicians, or other providers of medical services.

They also perform appeal functions in cases where patients, physicians, or hospitals seek review of a Medicare utilization or quality of care decision.

Finally, PROs are required to investigate all written complaints from patients about the quality of Medicare services. Therefore, if you have a complaint about the quality of care you receive from a hospital, hospital outpatient department, skilled nursing facility, HMO, or home health agency, you should send a letter to your PRO outlining your complaint. The PRO must investigate your complaint, take corrective action where necessary, and notify you of the outcome of its investigation.

If the PRO denies payment for your hospital admission, a procedure, or a continued stay, you can request that your case be reviewed. You have the right to ask the PRO to reconsider an initial denial of service. Appeal procedures vary, depending on whether the denial comes before the patient's admission to the hospital or during a hospital stay.

SURGERY

OUT - PATIENT

EMERGENCY

NOTE: For your maximum protection and full use of the appeal rights Medicare provides, pay particular attention in the following material to the deadlines for requesting quick PRO review.

Before a Hospital Admission: What If I Am Told Medicare Will Not Cover My Stay?

In the case of elective or nonemergency surgery, either the hospital or the PRO may be involved in the initial preadmission decision (in addition, of course, to your physician). Whether you should undergo a surgical procedure as an inpatient or an outpatient should be based solely on your medical needs.

1) If the hospital believes that your proposed stay will not be covered by Medicare, it may notify you that, in its opinion, Medicare would not pay for the hospitalization.

If you have not received a written notice and wish to have the denial of hospitalization reviewed, ask that the hospital put the decision in writing.

To receive a prompt review of that notice, call your PRO as quickly as possible; the PRO will then have three *working* days to respond to your request. If you do not make your request promptly, you may still write to ask for PRO review up to 30 days after receiving the hospital admission denial notice. In that case, the PRO will have 30 days after receipt of your written request to issue its response. In either case the PRO review decision will advise you of your further rights to a reconsideration and the time frames involved.

2) *When it is the PRO itself that initially denies your hospital admission, you must receive a written initial denial determination notice, stating:*

The reasons for denial and whether you would be liable for any part of the hospital bill;

Your right to an expedited reconsideration;

When and how to request a reconsideration; and

Where to file a request and submit additional information to support your case.

In the case of a PRO denial, you may obtain an expedited reconsideration by making your request within **three calendar days**. The PRO then has three *working* days to respond to such a request. If your request is submitted later than three *calendar* days following your receipt of a denial notice, you may still request a reconsideration up to 60 days after receiving that initial notice. The PRO in that case would have 30 days to reconsider.

Along with your request, submit any additional information you feel is important, including information from your medical history you do not think the PRO had initially.

The outcome of a PRO reconsideration will be either a decision that Medicare will pay for some or all of the services, or a confirmation that the initial denial was correct and appropriate.

The PRO's decision will be presented to you in writing. It should contain:

The basis for the PRO's decision;

A detailed rationale for the decision; and

A statement about your further appeal rights, including information on the proper procedures.

During My Hospital Stay: I Hear Stories about People Being Discharged Too Soon. What Can I Do to Avoid This?

If you feel you are being pressured to leave the hospital too soon, you have the right to ask that your case be reviewed by the PRO. Only the PRO is authorized to make a binding judgment as to whether Medicare will pay for your continued hospital stay.

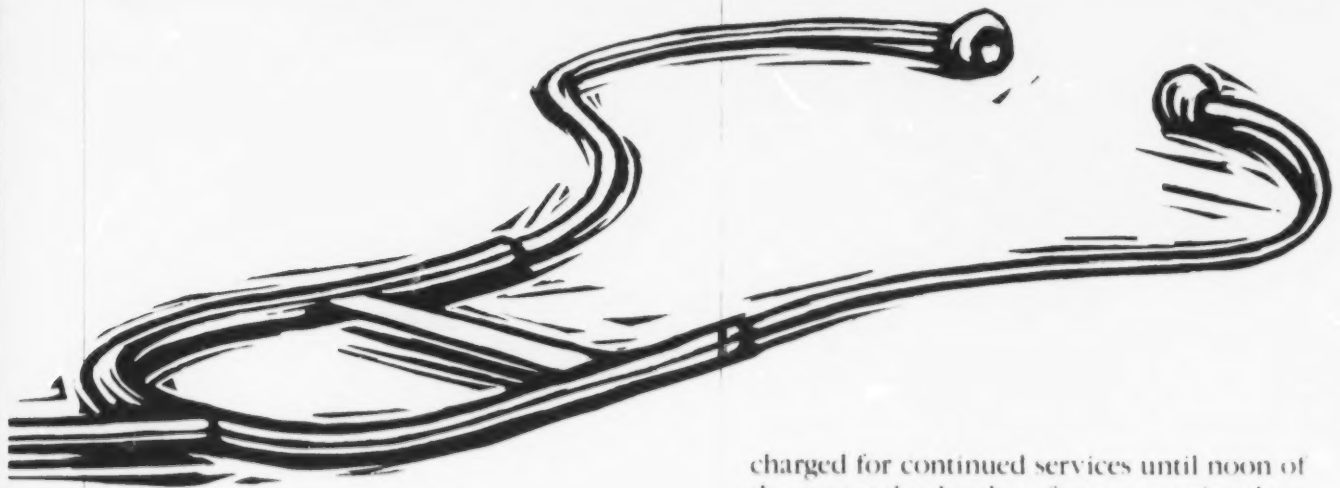


Under Medicare, a hospital may notify you that you no longer need inpatient care. In such a case, the hospital, with the agreement of either your physician or the PRO, must issue you a written *notice of noncoverage*. If you receive this notice, record the date of your receipt. If your hospital or physician verbally informs you that you no longer need inpatient care, and you wish a PRO review, ask the hospital to give you the written notice of noncoverage. This notice does not say you must leave the hospital. It does, however:

State that you no longer require inpatient hospital care and briefly gives the reasons;

Explain whether the hospital issued the notice with the agreement of your physician or the PRO;

Tell when you must begin to pay for your care;



Explain the appeals procedure;

Give you a phone number to call to begin an appeal; and

Require your signature (or your representative's) along with the date and time of receipt.

If you *disagree* with the *notice of noncoverage* and wish to remain in the hospital, here are the procedures to follow in order to obtain a review by the PRO: the procedures differ depending on whether the notice is issued with the agreement of your physician or the PRO:

- 1) *If you receive a notice that says your physician has agreed with the hospital's recommendation that you no longer need inpatient care —*

This is a *notice of noncoverage*. By **noon of the next workday** after receiving the notice, you, a family member or your representative must call the PRO at the number given in the notice and request an immediate review. The PRO, after contacting you to ask about your condition, must review your case and give you a decision no later than the next full workday after getting your request (the hospital must have sent the PRO all necessary medical records by the end of the day you made the request). If the PRO decides you should stay in the hospital, Medicare will cover the additional costs. If, however, the PRO agrees with your physician and the hospital, and approves the hospital *notice of noncoverage*, you cannot be

charged for continued services until noon of the next *calendar* day after you receive the PRO's negative decision.

What will happen if you stay in the hospital after receiving a *notice of noncoverage* but miss the one-day deadline to request an immediate PRO review? You can still call the PRO at any time during your stay and ask that it review your case. In that event, however, your liability for your hospital stay would begin to be counted from the third *calendar* day after you received the original hospital notice. At the same time, the PRO itself would have three *workdays* to review your case. Thus the end result of your missing the one-day deadline to request a review (in the event that the PRO agrees with the hospital *notice of noncoverage*) might be that you are charged for one or more days of your stay while you were waiting for the PRO's decision. **SO REMEMBER:** act quickly if you wish to challenge the hospital's notice.

In this first situation—a hospital *notice of noncoverage* given with the agreement of your physician—if the PRO decides your stay is not covered by Medicare, its decision is called an "initial denial determination." The determination notice will advise you of further rights to a reconsideration and the time frames involved.

- 2) *If you receive a notice stating that the hospital is seeking the PRO's approval of its decision that you no longer need hospital care (meaning that your physician has disagreed with the hospital) —*

This is **NOT** a *notice of noncoverage*. Because your physician disagreed, the hospital must obtain PRO approval before it can issue you a *notice of noncoverage*. The hospital

must notify you in writing that it is seeking PRO review and the PRO must contact you to inquire about your condition. Take advantage of this opportunity to present your views, so that the PRO has all the facts before making its decision.

If the PRO agrees with the hospital, the hospital, as well as the PRO, will send you the written *notice of noncoverage*. If you still believe it is too soon to leave the hospital, you, a family member, or your representative can call and ask the PRO for an expedited reconsideration. **Do so as quickly as possible.** In these cases (where notices have been issued with the PRO's approval, not your physician's), the PRO has three *workdays* from receipt of your review request to reconsider its original decision and notify you of the result. If the PRO upholds its original decision that you no longer need hospital care, your financial liability begins as of the third *calendar* day after you received the hospital *notice of noncoverage*. Thus your quick request is necessary to minimize the chances of being charged for at least one and possibly several more days of care while you await the PRO's reconsideration. Of course, if the PRO overturns its original decision and tells you to remain in the hospital, Medicare will continue to cover the costs.

Do I Have Another Alternative If the PRO's Reconsideration Decision Is Not in My Favor?

A PRO reconsideration determination is final and binding unless you request a further appeal (such as a Medicare hearing) in writing. If the amount in controversy is at least \$200, you can request a hearing by an administrative law judge in the Social Security Administration. Submit your request in writing within 60 days of your receipt of the PRO reconsideration decision. The PRO's reconsideration notice tells you where to file an appeal. If the judge rules unfavorably on the appeal, the appeals process can continue through judicial review, if the amount in question is at least \$2,000. Once you request an appeal hearing it is advisable to seek the assistance of an attorney.

What Type of Reviews Can the PRO Conduct After I Am Discharged?

After Medicare patients are discharged, the PRO review process considers whether hospital admission was necessary, whether the treatment was appropriate, and whether quality care was provided. Such review can result in your receiving a payment denial notice regarding services already provided. In the post-discharge review situation, either Medicare or the hospital, but not you, will be responsible for the denied expenses, unless 1) the hospital had informed you by written notice at the time of admission or during your stay that your care would not be covered by Medicare, or 2) you had received similar care before and were notified that it was not covered.

For hospital care received after January 1, 1988: if payment is denied and either Medicare or the hospital is responsible for the expenses, you are entitled to a refund of any deductible or coinsurance already paid. (You remain responsible for other costs not covered by Medicare, such as telephone charges and television rentals.) Arrangements for any refund due should be made with the fiscal intermediary handling your Medicare claim.

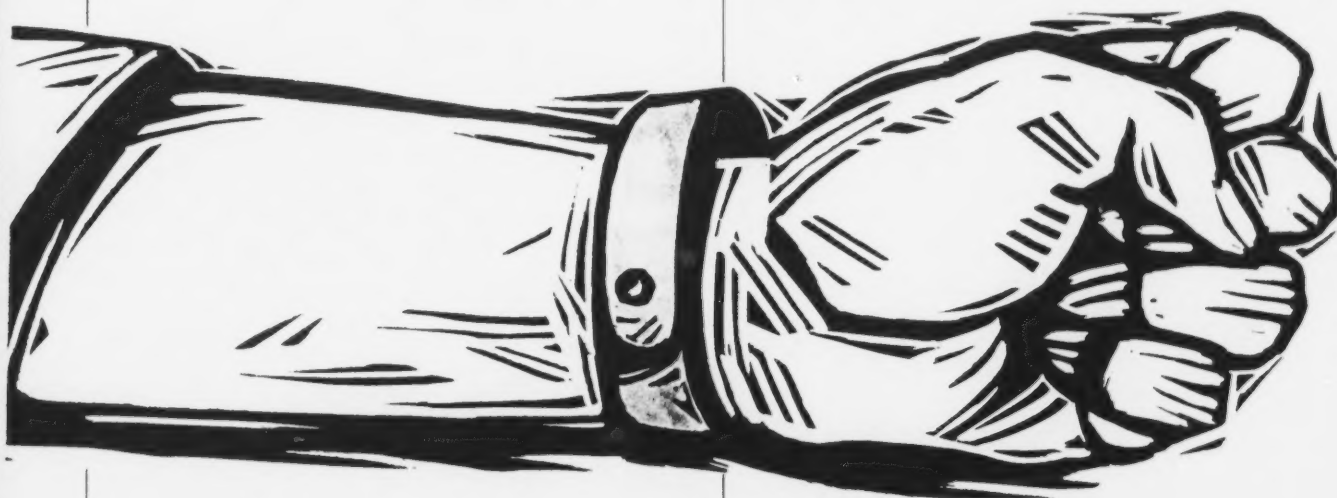
Examples of Beneficiary Discharge Appeal Rights

Situation One: Hospital, *with your doctor's agreement*, sends you a written *notice of non-coverage* stating that you no longer need hospital care and will have to pay for your stay beginning the third *calendar* day after receiving the notice.

1. To request an immediate review, you, a family member, or your representative must call the PRO by noon of the next *workday* after receiving the notice; request a PRO review.
2. The PRO must solicit your views before making its decision.
3. The PRO must send you, your doctor, and the hospital its decision within the next full *workday* after receiving your request and the necessary hospital records.
4. If the PRO agrees with you, Medicare will continue to pay for your hospital stay.
5. If the PRO agrees with your doctor and hospital, you will be charged beginning noon of the *calendar* day *after* you receive PRO decision.

Situation Two: Hospital wants to send you the written *notice of noncoverage* but *your doctor disagrees* that you are ready for discharge.

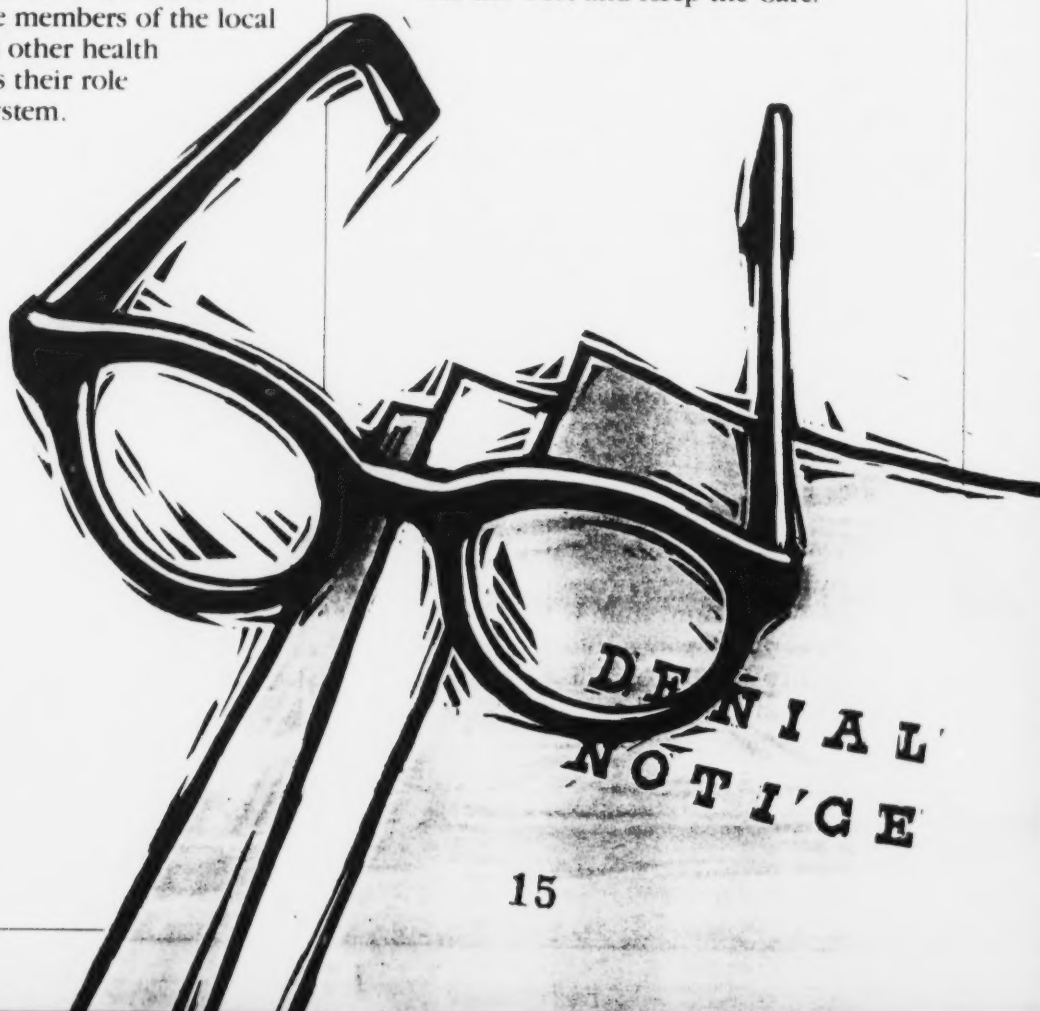
1. Hospital asks the PRO to review the case, and, at the same time, tells you in writing that it has done so.
2. The PRO must solicit your views in the process of reviewing the hospital's request. Take advantage of this opportunity to present your views so that the PRO has all the facts before making its decision.
3. If the PRO agrees with the hospital, both the PRO and the hospital send you a *notice of noncoverage* that you no longer need hospital care and that you will have to pay for your stay beginning the third *calendar* day after receiving the notice.
4. To request an expedited reconsideration, you, a family member, or your representative must call the PRO as quickly as possible.
5. The PRO has the next three *workdays* to reconsider your case.
6. If the PRO agrees with you and overturns the original decision, Medicare will continue to pay for your hospital stay.
7. If the PRO agrees with the hospital and upholds the original decision, you will be charged as of the third *calendar* day after receiving the *notice of noncoverage*; therefore, you could be liable for payment during some of the PRO reconsideration period.



Knowing Your Rights as a Medicare Beneficiary Is More Essential Now Than Ever Before

By picking up this booklet, you have taken the first step toward becoming your own best advocate. Your next step is to help your family, friends and neighbors better understand Medicare's *Prospective Payment System*. You may want to help organize an educational seminar in your community, explaining to the participants how the changes described in this booklet can affect them. You might invite members of the local PRO, hospital staff and other health professionals to discuss their role in the new payment system.

Remember that the American Association of Retired Persons (AARP) is dedicated to the goal of cutting health care costs while retaining the quality of patient care. By taking the responsibility of becoming a better *informed* consumer and helping others become better informed about the *Prospective Payment System*, you can join the campaign to "Cut the Cost and Keep the Care."



Peer Review Organizations (PROs)

Alabama

Alabama Quality Assurance
Foundation
Suite 300
236 Goodwin Crest Drive
Twin Towers East
Birmingham, Alabama 35209
1-800-554-5946
(205) 942-0785

Alaska

Professional Review Organization
for Washington Alaska Division
Suite 204
700 West 41st Street
Anchorage, Alaska 99503
1-800-445-6941
(907) 562-2252

Arizona*

Health Services Advisory Group, Inc.
Suite 157-B
301 E. Bethany Home Road
Phoenix, Arizona 85012
1-800-626-1577
(602) 264-6382

Arkansas

Arkansas Foundation for Medical
Care, Inc.
P.O. Box 1508
809 Garrison Avenue
Fort Smith, Arkansas 72902
1-800-824-7586
(501) 785-2471

California

California Medical Review, Inc.
Suite 1100
1388 Sutter Street
San Francisco, California 94109
1-800-841-1602
(415) 923-2000

Colorado

Colorado Foundation for Medical Care
Building 2, Suite 400
6825 East Tennessee Avenue
Denver, Colorado 80217
(303) 321-8642

Connecticut

Connecticut Peer Review
Organization
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Delaware PRO
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(202) 675-4612

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Professional Foundation for
Health Care
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Tampa, Florida 33629
1-800-634-6280
(813) 831-6273

Georgia

Georgia Medical Care
Foundation/PRO
Suite 1300
4 Executive Park Drive, N.E.
Atlanta, Georgia 30329
1-800-282-2614
(404) 982-0411

Guam and American Territories

FISCAL INTERMEDIARY
Hawaii Medical Services Association
P.O. Box 860
Honolulu, Hawaii 96808
(808) 944-2110

Hawaii*

FISCAL INTERMEDIARY
Hawaii Medical Services Association
P.O. Box 860
Honolulu, Hawaii 96808
(808) 944-2110

Idaho

Professional Review Organization
for Washington
Idaho Division
Suite 250
815 Park Boulevard
Boise, Idaho 83712
(208) 343-4617

Illinois*

Crescent Counties Foundation for
Medical Care
Suite 240
350 Shuman Boulevard
Naperville, Illinois 60540
(312) 357-8770

Indiana

PEERVIEW, Inc.
Suite 200
501 Congressional Boulevard
Carmel, Indiana 46032
1-800-421-6558
(317) 573-6888

Iowa

Iowa Foundation for Medical Care
Suite 500
3737 Woodland Avenue
West Des Moines, Iowa 50265
1-800-422-2234
(515) 223-2900

Kansas*

Kansas Foundation for Medical Care
2947 S.W. Wanamaker Drive
Topeka, Kansas 66614
1-800-432-0407
(913) 273-2552

Kentucky

PEERVIEW, Inc.
10300 Linn Station Road
Suite 100
Louisville, Kentucky 40223
1-800-423-6512
(502) 429-0995

Louisiana

Louisiana Health Care Review, Inc.
Suite 200
9357 Interline Avenue
Baton Rouge, Louisiana 70809
1-800-433-4958
(504) 926-6353

Maine

Health Care Review, Inc.
51 Broadway
Bangor, Maine 04401
1-800-541-9888
(207) 945-0244

Maryland

Delmarva Foundation for Medical
Care, Inc.
341-B N. Aurora Street
Easton, Maryland 21601
1-800-247-9770
(301) 822-0697

Massachusetts

Massachusetts Peer Review
Organization, Inc.
300 Bear Hill Road
Waltham, Massachusetts 02250
1-800-228-3297
(617) 890-0011

Michigan

Michigan Peer Review Organization
Suite 200
40500 Ann Arbor Road
Plymouth, Michigan 48170
1-800-482-4045
(313) 459-0900

Minnesota

Foundation for Health Care
Evaluation
Suite 700
1 Appletree Square
Minneapolis, Minnesota 55420
(612) 888-3423
(612) 54-3306

Mississippi

Mississippi Foundation for Medical
Care, Inc.
(1900 No. West Street ZIP 39202)
P.O. Box 4665
Jackson, Mississippi 39216
(601) 948-8894

Missouri

Missouri Patient Care Review
Foundation
311A Ellis Boulevard
Jefferson City, Missouri 65101
1-800-654-1016
(314) 634-4441

Montana

Montana-Wyoming FMC
111 No. Main Plaza Center, #201
Bozeman, Montana 59601
(406) 332-3411
(406) 443-4020

Nebraska

Sunderbruck Corp. of Nebraska
Suite 700 CTU Building
1221 N Street
Lincoln, Nebraska 68508
1-800-422-4812
1-800-624-8617 (after 6 p.m.)
(402) 474-7471

Nevada

Nevada Physicians Review
Organization
Building A, Suite 108
4600 Kietzke Lane
Reno, Nevada 89502
1-800-588-0829
(702) 826-1996

New Hampshire

New Hampshire Foundation for
Medical Care
P.O. Box 578
110 Locust Street
Dover, New Hampshire 03820
1-800-582-7174
(603) 749-1641

New Jersey

Peer Review Organization of New
Jersey, Inc., Central Div.
Brier Hill Court, Building J
East Brunswick, New Jersey 08816
(201) 238-5570

New Mexico

New Mexico Medical Review
Association
Box 9900
707 Broadway, N.E.
Albuquerque, New Mexico 87119
1-800-432-6824
(505) 842-6236

New York

Empire State Medical, Scientific
and Educational Foundation
420 Lakeville Road
Lake Success, New York 11042
1-800-331-7767
(516) 437-8134

North Carolina

Medical Review of North Carolina, Inc.
P.O. Box 37309
Suite 200
1011 Schaub Drive
Raleigh, North Carolina 27627
1-800-682-2650
(919) 851-2955

North Dakota

North Dakota Health Care
Review, Inc.
301 Mount Vernon Building
900 N. Broadway Avenue
Minot, North Dakota 58701
1-800-472-2902
(701) 852-4231

Ohio

Peer Review Systems, Inc.
Suite 250
3700 Corporate Drive
Columbus, Ohio 43229
1-800-233-7337 (in state)
1-800-237-7337 (out of state)
(614) 895-9900

Oklahoma

Oklahoma Foundation for Peer Review
Suite 400
The Paragon Building
5801 Broadway Extension
Oklahoma City, Oklahoma 73118
(405) 840-2891

Oregon

Oregon Medical Professional
Review Organization
Suite 300
1220 S.W. Morrison
Portland, Oregon 97205
1-800-452-1250
(503) 243-1151

Pennsylvania

Keystone PRO, Inc.
P.O. Box 618
645 N. 12th Street
Lemoyne, Pennsylvania 17043
1-800-322-1914
(717) 975-9600

Puerto Rico

Puerto Rico Foundation for Medical
Care, Inc.
Mercantile Plaza Bldg.
Suite 605
Hato Rey, Puerto Rico 00918
(809) 753-6706

Rhode Island

Health Care Review, Inc.
The Weld Building
345 Blackstone Boulevard
Providence, Rhode Island 02906
1-800-662-5028
(401) 331-6661

South Carolina

South Carolina Peer Review
Organization
1000 Carolina Commerce Center
Fort Mill, South Carolina 29715
1-800-843-0130
(803) 548-8400

South Dakota

South Dakota FMC
1323 South Minnesota Avenue
Sioux Falls, South Dakota 57105
1-800-952-3691
(605) 336-3505

Tennessee

Mid-South Foundation for Medical
Care, Inc.
Suite 400
6401 Poplar Avenue
Memphis, Tennessee 38119
1-800-873-2273
(901) 682-0381

Texas

Texas Medical Foundation
Suite 200
901 Mopac Expressway, South
Austin, Texas 78746
1-800-252-9216
(512) 329-6610

Utah

Utah PSRO
Suite 200
540 East 5th South
Salt Lake City, Utah 84102
(801) 532-7545

Vermont

New Hampshire FMC
P.O. Box 578
110 Locust Street
Dover, New Hampshire 03820
1-800-582-7174
(603) 749-1641

Virgin Islands

Virgin Islands Medical Institute, Inc.
P.O. Box 1566
#IAD Estate Diamond Ruby
Christiansted, St. Croix
Virgin Islands, 00820
(809) 778-6470

Virginia

Medical Society of Virginia Review
Organization
P.O. Box 6569
1904 Byrd Avenue
Room 120
Richmond, Virginia 23230
1-800-533-1745
(804) 289-5320

Washington

Professional Review Organization
for Washington
Suite 200
2150 N. 107th Street
Seattle, Washington 98133
1-800-233-5439 (residents)
1-800-445-6941 (outside of state)
(206) 364-9700

West Virginia

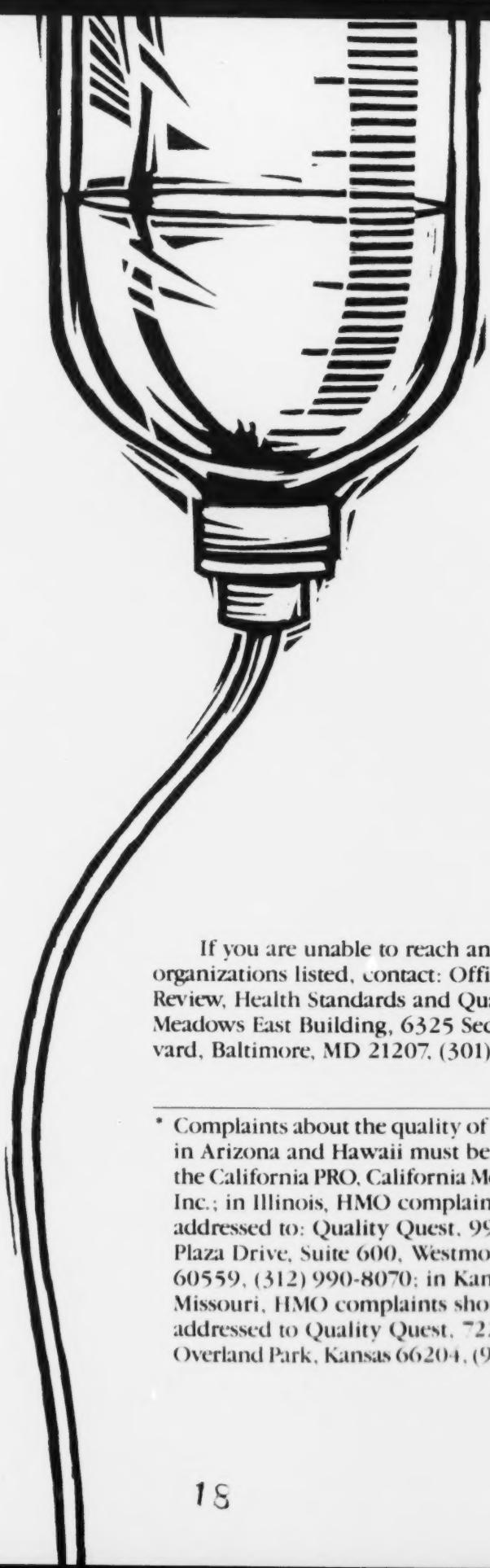
West Virginia Medical Institute, Inc.
3412 Chesterfield Ave., S.E.
Charleston, West Virginia 25304
1-800-642-8686
(304) 925-0461

Wisconsin

Wisconsin Peer Review Organization
P.O. Box 1109
2001 West Beltline Highway
Madison, Wisconsin 53713
1-800-362-2320
(608) 274-1940

Wyoming

Montana-Wyoming FMC
Placer Center, #201
21 N. Main Street
Helena, Montana 59601
1-800-826-8978
(406) 443-4020



If you are unable to reach any one of the organizations listed, contact: Office of Medical Review, Health Standards and Quality Bureau, Meadows East Building, 6325 Security Boulevard, Baltimore, MD 21207. (301) 966-6851.

* Complaints about the quality of care in HMOs in Arizona and Hawaii must be addressed to the California PRO, California Medical Review, Inc.; in Illinois, HMO complaints should be addressed to: Quality Quest, 999 Oakmont Plaza Drive, Suite 600, Westmont, Illinois 60559, (312) 990-8070; in Kansas and Missouri, HMO complaints should be addressed to Quality Quest, 7227 Metcalf, Overland Park, Kansas 66204, (913) 384-1700.

Patient Checklist

Before Checking into the Hospital . . .

- ☐ **Ask your doctor if the prescribed treatment could be safely and effectively administered on an outpatient basis.**
- ☐ **Begin to calculate what your estimated out-of-pocket hospital costs will be.** As soon as you know you may be admitted to the hospital, discuss with your doctor your treatment options and anticipated length of stay. Based upon this, you should be able to estimate your costs, including the first-day deductible and coinsurance payments after 60 days. Remember to include costs for items and services not covered by Medicare, such as telephone and television fees.
- ☐ **Enlist your physician's help.** Ask your physician to explain to you and your family how the Prospective Payment System can be expected to affect your care in the hospital.
- ☐ **Consider asking someone to assist you.** You may decide to have a friend or relative act as your representative and be available to make inquiries on your behalf should it be necessary while you are in the hospital. This person should be familiar with the material in this booklet.
- ☐ **Make initial plans for post-hospital health care.** Ask your physician about anticipated care/treatment options that may be necessary after discharge from the hospital. For example, ask if you will be able to go directly home or if you will need nursing home care or home health care services following hospitalization. Prearrange for the services you may need after being discharged. Check on the cost of services and whether Medicare will pay for the services you'll need when you leave the hospital.
- ☐ **Look over your private insurance policy.** See what it does or doesn't cover. Most people are surprised to find that both Medicare and their supplemental insurance policies provide very limited coverage for nursing home or home health care.

Upon Entering the Hospital . . .

- ☐ **Be sure to take this booklet with you for information on the PRO review process.**
- ☐ **Read everything you sign at admission, especially financial and "informed consent" documents.** The hospital staff should be able to answer any questions you have about these forms. Never sign anything you do not understand.
- ☐ **Be sure the hospital gives you a copy of "An Important Message from Medicare," a government-mandated statement that informs you of your rights to needed medical care and how to use the PRO appeals system.**
- ☐ **Find out who on the hospital staff handles discharge planning (for example, Social Services).** Identify who will be responsible for planning any other services you will need when you are discharged from the hospital. Write down this person's telephone number for easy access during your hospital stay.
- ☐ **Keep the address and telephone number for the PRO in your area handy.** The address and telephone number for each PRO is provided with the list at the back of this booklet.



While You Are in the Hospital . . .

☐ **For questions about medical treatment, contact your physician.** Your physician is the one who establishes the plan for your medical treatment, who decides when you should be discharged from the hospital, and who can make important recommendations about your care after you leave the hospital. Share any concerns as soon as possible.

☐ **For questions about nursing or other hospital services, contact the registered nurse (R.N.) responsible for your care.** Other hospital personnel who may be able to answer questions about hospital policy or nursing services include the hospital's nursing director, social services director or patient ombudsman.

☐ **If it is recommended by the hospital that you no longer need inpatient care,** you have the right to:

Receive a written notice that you will be liable for services beginning on the third calendar day after your receipt of the notice;

Continue to receive care covered by Medicare for the two-day period before your liability begins; and

Request an immediate review by the PRO.

☐ **Remember to keep copies of all documents and bills for your records.**

My PRO is:

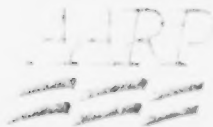
Name: _____

Address: _____

Phone: _____

Notes

A publication of
Health Advocacy Services
Program Department



American Association of Retired Persons
1909 K Street, N.W.
Washington, DC 20049